

PART 6

ACCREDITATION

INDIAN HEALTH SERVICE
 DIVISION OF FACILITIES AND ENVIRONMENTAL ENGINEERING
 FACILITIES ENGINEERING OPERATIONS MANUAL
PART 6 - ACCREDITATION

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CHAPTER 1 - INTRODUCTION

1-1 PURPOSE

The purpose of this document is to present an overview of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements that Facilities Managers must contribute towards the accreditation effort at their installation. This document is intended for Facilities Managers who are responsible for facilities engineering, clinical engineering and safety management (safety officer) at a typical Indian Health Service (IHS) installation.

1-2 BACKGROUND

- A. Accreditation is the process of validating the quality of health care practiced at an installation. Validation is performed by a survey team of health care professionals who visit the health care site to verify that the institution meets or exceeds minimum acceptable standards established by the accrediting body.
- B. Only health care programs designated to be accredited by the IHS Governing Body are surveyed for accreditation. Accrediting organizations do not mandate the programs that have to be accredited nor the buildings that need to be toured for life safety compliance. They only accredit what they are asked to validate for accreditation. It is possible that at times the IHS Governing Body may elect not to submit for accreditation some health care programs until they are fully implemented to meet the standards.
- C. Accreditation is a benchmark for the government to ascertain to the Indian people that the quality of health care at an IHS facilities that is accredited, is as good as the care provided by other accredited health care organizations in the private or public sector.

1-3 ACCREDITING BODIES

- A. GENERAL - There are numerous health care accrediting organizations in the United States. Some only validate specialized fields, i.e., inpatient, nursing home, drug and alcohol, psychiatry, others like JCAHO validate all health care programs. Accreditation is not mandatory nor permanent. Installations are re-surveyed generally every three years. Only programs that are surveyed at a site are accredited, not the entire installation. Accreditation surveys occur upon written

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request by the installation. A fee is paid for the validation process.

- B. JCAHO - The Joint Commission on Accreditation of Hospitals is the current health care accrediting organization used by the IHS to validate its health care programs. JCAHO is a private non-profit organization. The JCAHO standards that a Facilities Manager has to be concerned with are found in the Environment of Care (EC) section of the JCAHO standards.
- (1) Facilities Managers must coordinate the completion of a JCAHO document called the Statement of Conditions. A separate document is required for each building where patients receive treatment. The document must be presented to the JCAHO surveyors the first day of the survey. The document is a questionnaire that evaluates a building's compliance with the Life Safety Code.
 - (2) Buildings for which JCAHO does not receive a statement of conditions automatically are not included in the life safety evaluation of the survey.
 - (3) Only buildings that house programs where the IHS Governing Body has requested accreditation require a statement of conditions. If a program has patient's treated in several buildings, then each building where treatment occurs requires a statement of condition. If a portion of a building is utilized for a program to be accredited a statement of condition for the entire building is required.

Close coordination is necessary between the Facilities Manager and the Governing Body at their installation. Facilities Managers could mistakenly create a conflict if they fail to submit statements of condition for health care programs requested for survey by the Governing Body.

- B. HCFA - Another organization that we are concerned about in the health care field is the Health Care Finance Administration (HCFA). This is an agency of the Public Health Service that is responsible for validating installations against standards slightly different than JCAHO. The importance of HCFA is that it is the entity that allows health care organizations in the private and public sector to collect Medicare and Medicaid (M&M) funds. Health care performed under programs that are not accredited are not eligible for collection of M&M funds. HCFA generally does not conduct its own surveys. They are delegated to the States. HCFA accepts JCAHO surveys to allow IHS collection of M&M funds. M&M funds are an additional source of revenue for our installations to use in addition to the funding received from the Congress.

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1-4 JCAHO SITE SURVEY TEAMS

- A. Accreditation site surveys are conducted by personnel who work for, or are consultants under contract with JCAHO. Survey teams are generally composed of at least a physician, a hospital administrator, and a nurse. Occasionally other specialized surveyors may also be part of the survey team.
- B. An opening conference between installation management officials and the JCAHO surveyors starts the survey. Following the opening conference, the survey team is assigned a conference room at the site. The team reviews accreditation documentation for the 12 months previous to the survey. During the site survey a couple of hours are scheduled by the surveyor administrator to tour the buildings and grounds with the Facilities Manager and the safety officer. The purpose of this tour is to randomly verify compliance with the Life Safety Code. Life safety deficiencies, that exists at the installation, should have been identified in Part 4 of the Statement of Condition. All life safety deficiencies identified in the statement of conditions will not be cited by JCAHO in the survey report if a reasonable plan of correction is in place. In addition to the tour and review of the documentation, the survey team interviews department heads, supervisors, hospital staff, and patients.
- C. On the last day of the survey, the survey team conducts an exit conference with top management at the installation. The conference primarily focuses on the accreditation deficiencies identified by the survey team and the recommendations for improvement the final report will offer for full compliance with the standards.
- D. A final written report is sent to the installation approximately 45 days after the survey. In the final report the installation is rated as accredited, conditionally accredited or not accredited and is asked to respond in writing to any corrective actions recommended in the report.

1-5 PERFORMANCE FOCUSED ACCREDITATION

- A. The intent of the new JCAHO methodology is to focus on recurring assessments for evaluating compliance with the standards. If a deficiency is identified, corrective action is recommended, and the implementation is monitored for compliance. The idea is to empower Facilities Managers to be concerned about performance and productivity. Its goal is to require managers to evaluate program performance on a scheduled basis so that there is assurance that programs operate continuously at the highest

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possible level. The key is to find out why something went out of track so that it can be avoided in the future. No Facilities Manager should ever object to this train of thought. The intent is to implement performance focused accreditation.

- B. Facilities Managers must develop performance standards to use when evaluating their programs. Performance standards are pre-approved performance criteria established as a baseline to compare against completed or accomplished work. The comparison yields information utilized to evaluate the program and either validate, improve or correct the program.

Characteristics of a good performance standard:

- (1) Measures an important parameter
- (2) Is clearly defined
- (3) Is easily understood by the staff
- (4) Is easy to obtain and inexpensive to accumulate

1-6 NEW SURVEY STRATEGIES

- A. Previous to 1995, JCAHO required that each department maintained its own documentation for their portion of compliance with the standards. The new process moves away from evaluating documentation at the department level. It focuses on evaluating the overall program. This is accomplished by verifying that a plan has been developed to establish the requirements (management plans), that it is implemented (procedures and training), and that it is evaluated periodically (effectiveness reviews).
- B. Prior to 1993 installations were very much aware of the survey schedule for their installation. Generally they would gear up for the survey a couple of months before the "big day". However, since July 1993 JCAHO has been conducting un-announced surveys as a check and balance to ensure continuous implementation of accreditation requirements. Using un-announced surveys JCAHO can identify installations that are not implementing compliance on a continuous basis.

Un-announced surveys focus on:

- (1) Safety Management
- (2) Infection Control
- (3) Patient Rights

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- (4) Credentialing
 - (5) Management and Administration
- C. Un-announced surveys may occur when there are indications of serious problems with clinical care at a particular accredited health care site. A possible indication is an immediate threat to patient health/safety and/or evidence that falsified information has been submitted to ensure accreditation.

1-7 CUSTOMER EXPECTATIONS

- A. Facilities Managers need to confer with other department heads (customers) in order to determine their expectations of the maintenance program. Without an assessment of what the customer expects from the maintenance department the Facilities Manager may well find out that the program is going in the wrong direction.

Factors that need to be reviewed include:

- (1) Adequacy of work request prioritization methodology
 - (2) Adequacy of response time to accomplish work orders
 - (3) Adequacy of maintenance funding
 - (4) Adequacy of the preventive maintenance program
 - (5) Adequacy and reliability of utility systems
 - (6) Adequacy of repair and maintenance scheduling
 - (7) Adequacy of maintenance procedures
 - (8) Adequacy of communication with subordinates and staff
- B. When Facilities Managers identify deficiencies generally they require the expenditure of additional funds and/or manpower. As a direct result of this, budget and staffing must be evaluated against the customer's expectations. An increase in budget and staffing may be impossible in the current funding climate.
- (1) The expectations of the customers served by the maintenance department may not be in line with what the Facilities Manager can deliver to the customers. The service unit director may not be aware that the maintenance department cannot produce, due to lack of funds and/or manpower, what the customers expect. If this is true, it needs to be

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brought to the attention of management.

- (2) If an evaluation of the maintenance program reveals that a difference exists between customer expectations and desired results, adjustments must first be made by considering all of the available alternatives. Alternatives are service contracts and a reduction in the amount of PM performed in-house by a reduction in the frequency of the PM work. This will ensure that the desired delivery of service is achieved if it is in line with upper management's expectations.

C. Steps to make the maintenance program work are:

- (1) Define the customer's needs;
- (2) Determine customer's expectations;
- (3) Establish requirements for the expectations;
- (4) Create a strategy to achieve the results;
- (5) Develop standards to evaluate performance;
- (6) Deliver the requested service to the customer;
- (7) Track the service delivery;
- (8) Analyze the collected information;
- (9) Adjust services to achieve the customer's expectation.

1-8 PTSM VERSUS EC STANDARDS

- A. The previous JCAHO accreditation standards that were identified with the maintenance department were referred to as the Plant Technology and Safety Management or PTSM standards. These standards were usually unfairly assigned to the maintenance department in its entirety.

The PTSM standards were really directed to:

Safety Management (PL 1) - Service unit director, safety officer, and all department heads.

Life Safety Management (PL 2) - Service unit director, safety officer, and all department heads.

Equipment Management (PL 3) - Facilities Manager, all department heads, all equipment users and maintainers.

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Utilities Management (PL 4) - Facilities Manager, all department heads, utility users, and maintainers.

- B. Every department is now required to be involved in order for the outcome to achieve success. The old PTSM standards have now been replaced with EC standards. The EC stands for Environment of Care.

The new standards are directed to;

Design (EC.1) - Headquarters Division of Facilities Planning and Construction (DFPC), Engineering Service (ES), Area facilities engineer, service unit director, Facilities Manager and selected department heads as appropriate.

Implementation (EC.2) - Service unit director, department heads, service unit safety committee.

Measurement Systems (EC.3) - Service unit safety committee.

Social Environment (EC.4) - Governing body, service unit director, clinical director and clinical department heads.

Smoking (EC.5) - Governing body, service unit safety committee, and clinical director.

1-9 COMPLIANCE SCORING

JCAHO uses five categories to rate installations:

	<u>CATEGORIES</u>	<u>SCORE</u>
A.	<u>SUBSTANTIAL COMPLIANCE</u> "Consistently meets the standards" (12 months prior to the survey)	91 - 100%
B.	<u>SIGNIFICANT COMPLIANCE</u> "Meets most standard provisions" (9 - 11 months prior to the survey)	76 - 90%
C.	<u>PARTIAL COMPLIANCE</u> "Meets some provisions" (6 -8 months prior to the survey)	51 - 75%
D.	<u>MINIMAL COMPLIANCE</u> "Meets few provisions" (5 months or less prior to survey)	LESS THAN 50%
E.	<u>NONCOMPLIANCE</u> "Fails to meet the standards"	

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(No process, policy or procedures)

Ratings of D or E most likely will result in issuance of Type I recommendations with the requirement of a follow-up survey to verify compliance.

1-10 SURVEY REPORT LANGUAGE

- A. Surveyors review program documentation and implementation against the standards. As a result of the survey, if deficiencies are found, recommendations are issued that if implemented, will correct the deficiencies found during the survey.
- B. The types of recommendations outlined below will introduce you to the language found in the final report. This will assist you in interpreting the installation's rating for the survey.
- (1) **Type I Recommendation** - This is a serious recommendation that impacts strongly on the accreditation decision. It requires follow-up written response by the installation. One Type I recommendation prevents the installation from receiving a commendation even if everything else is perfect.
 - (2) **Type II Recommendation** - This type of recommendation impacts the next survey cycle. Surveyors will be monitoring it closely during the following survey three years later.
 - (3) **Implementation Monitoring** - Requires extended correction time and is not considered in the accreditation decision.
 - (4) **Plan of Correction** - Cited on existing major life safety deficiencies at the time of the survey. Require interim life safety measures implemented until corrective action is completed. A detailed written plan of action outlining the source of funds and a completion timetable is required.

1-11 TERMINATION OF ACCREDITATION

On some occasions an installation that is already accredited and is being surveyed again on its scheduled cycle may be found so out of compliance that the surveyors may determine that accreditation should be terminated immediately.

Some of the reasons for termination may be:

- A. An immediate threat to patient or public health and safety exists within an installation.

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- B. Clinicians who do not possess a license are acting within the organization in a manner that would, under law, require a license.
- C. JCAHO surveyors are reasonably persuaded that the installation submitted falsified documents or misrepresented information to achieve or retain accreditation.
- D. An installation receives conditional accreditation in the current accreditation cycle in one program element and, in the previous accreditation cycle, the organization had also received conditional status in another program element.
- E. Conditional accreditation exists for two elements within the same program within the same accreditation cycle.

CHAPTER 2 - STRUCTURE OF THE ENVIRONMENT OF CARE

2-1 SCOPE

JCAHO envisions the management of the environment of care as a cycle of design, training, implementation, measurement, evaluation, and improvement. This concept should not seem strange to a Facilities Manager. When a new piece of equipment is installed the equipment is inspected and tested. The test results are compared against performance specifications which the equipment must meet before it can be accepted. When the equipment is installed employees that will maintain and/or operate the equipment receive training before start up. The idea being that if the staff is trained in the proper methods to use and maintain the equipment it will operate and be maintained more reliably. Good engineering practice further requires that periodically the equipment be tested to ensure that it is continuously operating as intended. If testing reveals deficiencies, adjustments are made to the equipment to bring it to acceptable performance. This is the same methodology envisioned for the implementation of the environment of care standards.

2-2 STANDARDS

The environment of care has been arranged into five standards.

- A. **DESIGN (EC.1)** - The organization designs a safe, accessible, effective, and efficient environment of care consistent with its mission.
- (1) **Selected Criteria**
- a. **Life Safety (EC.1.1)** - Newly constructed and existing health care installations are designed and maintained to comply with the Life Safety Code.
- b. **Space (EC.1.2)** - When determining the space requirements at an installation the organization considers using the Guidelines for Construction and Equipment for Hospitals and Medical Facilities.
- (2) **Management Plans (EC.1.3 to 1.9)** - The scope of the environment of care at a health care installation is defined by JCAHO into eight environment of care elements.

The environment of care program elements are;

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- a. Design EC.1
 - b. Safety Management EC.1.3
 - c. Security Management EC.1.4
 - d. Hazardous Materials and Wastes Management EC.1.5
 - e. Emergency Preparedness Management EC.1.6
 - f. Life Safety Management EC.1.7
 - g. Medical Equipment Management EC.1.8
 - h. Utilities Management EC.1.9
- (3) Management plans are developed to establish the requirements of each of the program elements.
- B. **IMPLEMENTATION EC.2** - The organization implements the environment of care program elements to provides a safe, accessible, effective, and efficient environment of care.
- Implementation is accomplished through;
- (1) Staff Knowledge (EC.2.1) - Staff members are trained on the requirements for implementing the environment of care. This training imparts employees with the knowledge and skills to perform their responsibilities described in the management plans.
 - (2) Management Plan Implementation (EC.2.2 to 2.8) - Procedures are written to implement the program elements.
 - (3) Emergency Drills (EC.2.9 and 2.10) - Drills are conducted to test procedures and staff knowledge in their assigned duties during an emergency.
 - (4) Inspect, Test, and Maintain (EC..2.11) - Equipment directly related to implementation of each of the program elements is maintained, tested, and inspected.
- C. **INFORMATION COLLECTION AND EVALUATION SYSTEM (EC.3)** - The installation develops and implements an information collection and evaluation system used to collect data to evaluate the performance of the environment of care.
- This is accomplished through;
- (1) Data Collection Responsibilities (EC.3.1) - The organization

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appoints a safety officer to direct an ongoing, organization wide process to collect information about deficiencies and opportunities to improve the environment of care.

- (2) Safety Committee Responsibilities (EC.3.2) - The safety committee analyses identified deficiencies and develops recommendations for resolving them.
- (3) Improvement Implementation Responsibilities (EC.3.3) - The safety officer works with appropriate staff to implement safety committee recommendations and monitor their effectiveness.

D. **SOCIAL ENVIRONMENT (EC.4)** - The installation establishes a social environment that supports its mission and services.

This is accomplished through;

- (1) Appropriate Space for Programs (EC.4.1) - Appropriate space to support services is provided.
 - a. Personal Hygiene (EC.4.1.1) - Articles for grooming and personal hygiene that are appropriate to the patient's age, developmental level, and clinical status are readily available.
 - b. Personal Property Storage (EC.4.1.2) - Closet and drawer space is provided for storing personal property and other items used by patients.
- (2) Space to Foster the Patient's Self Image (EC.4.2) - The environment provided for the patient fosters a positive self-image and preserves his or her human dignity.
 - a. Appropriate Use of Door Locks and Structural Restraints (EC.4.2.1) - Door locks and other restraints used are consistent with the hospital's mission and program goals.
 - b. Patient Clothing (EC.4.2.2) - Hospitalized patients wear clothing suitable to their clinical condition.
- (3) Adequate Privacy for Patients (EC.4.3) - Adequate privacy to reflect sensitivity and respect for the patient is provided.
 - a. Telephones (EC.4.3.1) - A telephone is available for private conversations by patients.
 - b. Privacy in Sleeping Rooms (EC.4.3.2) - Sleeping rooms have doors for privacy, unless clinically

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contraindicated.

- c. Patients per Room (EC.4.3.2.1) - The number of patients per room is appropriate to the installation's goals, the patient's age, developmental levels, and clinical needs.
- (4) Activities to Support Patient Interest (EC.4.4.4) - Interest to support the development and maintenance of the patient's interests, skills, and opportunities for personal growth are provided.
- a. Furnishings and Equipment (EC.4.4.1) - Furnishings and equipment appropriate to the population served are available.
 - b. Outdoor Activities (EC.4.4.2) - As appropriate to the length of stay, the hospital accommodates the needs of patients to be outdoors, unless contraindicated for therapeutic reasons.
- E. SMOKING (EC.5) - A no smoking policy is communicated and enforced throughout all buildings housing patients.

Medical Staff Criteria (EC.5.1) - Any exception for a patient is authorized in writing by the patient's physician's based on criteria defined by the medical staff.

2-3 STRUCTURE OF THE GUIDELINE

This guideline has been organized into chapters. Its purpose was to facilitate the user in deciding what is required for compliance by each program element. If only some program elements fall under ones responsibility then only those chapters are relevant to ones responsibility.

The structure of the document is as follows:

- A. CHAPTER 1 - This chapter is an introduction to the health care accreditation process.
- B. CHAPTER 2 - This chapter outlines the development of the JCAHO environment of care.
- C. CHAPTER 3 - This chapter outlines the first program element which deals with the design of health care facilities. The element encompasses the requirements, i.e, codes, standards and guidelines to build new and/or maintain existing installations.

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- D. CHAPTERS 4 to 10 - Each chapter relates to the requirements to develop, educate (staff), implement, and evaluate each of the other seven program elements.
- E. CHAPTER 11 - This chapter relates to the development of an information collection system. This is necessary for all program elements.
- F. CHAPTER 12 - This chapter relates to the social environment for the patient. This is not a requirement that falls under the purview of a Facilities Manager as it relates to clinical care. However, the impact of the requirement usually generates work orders or projects that will involve Facilities Managers.
- G. CHAPTER 13 - This chapter relates to the requirement of prohibiting smoking in all buildings where patients are treated unless authorized by a physician. This is a Governing Body, clinical staff, and safety committee issue.

Users are cautioned that some of the program elements may not be under their direct responsibility. All program elements however, require indirect responsibility since they may require implementation at some or all departments.

2-4 REQUIREMENTS FOR COMPLIANCE

In order to implement and fully comply with the new standards the following requirements need to be developed and implemented for each program element.

A. MANAGEMENT PLANS

Management plans are written narratives that describe and specify the minimum requirements the organization will provide to implement each program element. A management plan is required for each of the environment of care program elements.

B. PROCEDURES

Standard operating procedures (sop's) are narratives written for each applicable departments at the installation. These procedures specify departmental requirements to accomplish what was established by management (in the management plan) as the minimum requirements for implementing the environment of care program elements.

Procedures should address at a minimum:

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- (1) Purpose
- (2) Policy
- (3) Procedures (What and How will it be done)
- (4) Responsibilities (Who is going to do what)
- (5) References (What requires that it be done)
- (6) Distribution (Who receives copies)

C. **STAFF ORIENTATION AND EDUCATION**

Orientation and refresher training is required for users and maintainers of equipment, and personnel who implement the requirements of a program element as established in the management plan.

Training addresses:

- (1) New employee orientation;
- (2) Recurring refresher training;
- (3) Capabilities, limitations, and special applications;
- (4) Basic operating and safety procedures that personnel need to follow when implementing the requirements of a program element, i.e., using utilities; reporting of problems, failures, and user errors;
- (5) Information and skills maintainers need to perform their assigned duties; and
- (6) Location and use of emergency shutoff controls.

D. **EMERGENCY DRILLS**

Emergency drills are simulated occurrences performed at random to rehearse and evaluate employee and equipment response to emergency conditions.

Emergency drills are only required for:

- (1) Disaster Drills (Emergency Preparedness)
- (2) Fire Drills (Life Safety)

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E. PERFORMANCE STANDARDS

Performance standards are criteria (minimum acceptable parameters) used to measure and evaluate the effectiveness of a program element.

Performance standards address:

- (1) User and maintainer knowledge and skill requirements regarding their role in the utilities management program;
- (2) Routine emergency and incident reporting procedures, including when and to whom such reports are to be communicated; and
- (3) Inspections, preventive maintenance, and testing of utility systems.

F. EFFECTIVENESS REVIEW

- (1) Effectiveness reviews are annual assessments of each environment of care program element. The reviews are conducted by the safety committee. The assessments compare the data generated previous to the review against pre-identified performance standards to evaluate past performance of a program element.

An effectiveness review addresses:

- a. Name of the program element being assessed;
 - b. Criteria used to measure the effectiveness;
 - c. Findings;
 - d. Recommendations; and
 - e. Follow Up Action (if applicable).
- (2) A written report of the assessment conducted by the individual responsible for the program element is submitted for review through the safety committee, to the Governing Body for approval.

2-5 RESPONSIBILITIES

The goal of the management of the environment of care function is to provide a functional and safe environment for patients, employees, and

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visitors.

The following responsibilities are assigned:

A. SAFETY COMMITTEE (SAFETY OFFICER)

- (1) Plans, designs, and implements the environment of care;
- (2) Develops management plans for each of the required program elements;
- (3) Establishes and develops training programs for each program element for each affected department;
- (4) Develops performance standards to conduct effectiveness reviews of each program element;
- (5) Develops and implements an installation-wide data collection and evaluation system;
- (6) Conduct effectiveness reviews of each program element;
- (7) Submits a report of the effectiveness reviews conducted by the committee for approval by the Governing Body;
- (8) Monitors implementation of changes resulting from effectiveness reviews.

B. FACILITIES MANAGER

- (1) Assist the safety committee in the planning, design and implementation of the environment of care;
- (2) Implements management plans appropriate to the facilities program;
- (3) Develops and implements management plans for;
 - a. Utilities Management
 - b. Medical Equipment
- (4) Develops and implements a training program for facilities and clinical engineering employees on their facilities duties in the requirements of the environment of care program elements;
- (5) Develops and implements performance standards to measure the effectiveness of utilities, and medical equipment management program elements;

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- (6) Reports to the safety committee any incidents required by management plans;
- (7) Implements safety committee recommendations that require implementation by the facilities staff;
- (8) Monitors implementation of safety committee recommendations. Reports feedback as required by management plans;
- (9) Develops and implements a data collection and evaluation system for utilities and medical equipment management;
- (10) Conducts an annual effectiveness review of appropriate program elements. Submits a written report for review by the safety committee and approval of the Governing Body;
- (11) Coordinates completion of the necessary statements of condition for each building the Governing Body has submitted a program to be accredited.

C. DEPARTMENT HEADS

- (1) Assist management in the planning, design and implementation of the environment of care;
- (2) Implement management plans as applicable to their department;
- (3) Assist the safety committee in developing management plans as requested.
- (4) Develop and implement training plans for subordinate employees. Training includes all the program elements applicable to their department.
- (5) Report to the safety committee any incidents required by management plans.
- (6) Implement safety committee recommendations that require implementation by the department heads.
- (7) Monitor implementation of safety committee recommendations. Report feedback as required by management plans.

CHAPTER 3 - DESIGN OF THE ENVIRONMENT OF CARE

3-1 STANDARDS

DESIGN OF THE ENVIRONMENT OF CARE (EC.1) - The organization designs a safe, accessible, effective, and efficient environment of care consistent with its mission, services, and law and regulation.

CODE COMPLIANCE (EC.1.1) - Newly constructed and existing environments are designed and maintained to comply with the Life Safety Code.

SPACE GUIDELINES (EC.1.2) - When designing the environment of care, the organization considers using the Guidelines for Construction and Equipment for Hospitals and Medical Facilities (Guidelines).

ACCESSIBILITY (EC.2) - The organization provides a safe, accessible, effective, and efficient environment of care consistent with its mission, services, and law and regulation.

3-2 REQUIREMENTS FOR COMPLIANCE

- A. Required Statements of Conditions are prepared;
- B. Buildings in which patients are housed overnight or receive treatment are in compliance with the appropriate occupancy chapters of NFPA 101, Life Safety Code;

OR

- (1) Documentation of equivalencies, if any, have been submitted and approved by JCAHO prior to the survey;
- (2) A written plan of correction addresses all life safety deficiencies identified in the Statement of Conditions, Part 4, Plan of Correction.

NOTE:

Facilities Managers have access to a listing of deficiencies at their installation. Deficiencies if present, can be found in the latest Facilities Condition Survey (Deep Look printout) under deficiency category 2, Fire & Life Safety.

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If life safety deficiencies have been identified, a written Life Safety Management Plan for correction of the deficiencies must be made available to the surveyor the first day of the survey.

- (3) The plan of correction consists of the following:
- a. Corrective actions must be fully explained in writing;
 - b. A statement describing the source, availability, and commitment of the funds to correct the deficiencies;
 - c. A realistic timetable for completely correcting each deficiency;
 - d. Prioritization of all the deficiencies in the plan;
 - e. Estimated cost for correction of each deficiency.
- C. A written interim life safety plan, if applicable, outlining the measures that will be implemented to compensate for the deficiencies until corrective action is completed.

NOTE:

Implementation of interim life safety measures are only necessary if they are deemed serious enough in the opinion of the Authority Having Jurisdiction.

- D. Documentation that all buildings used by patients are in compliance with the American With Disabilities Act (ADA).

3-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. The Statement of Conditions prepared for each building where patients are treated at the installation;
- B. Statement of Condition; Part 4, Plan of Correction; and
- C. The Interim Life Safety Plan (if applicable).

CHAPTER 4 - SAFETY

4-1 STANDARDS

MANAGEMENT PLAN (EC.1.3) - A management plan addresses safety.

IMPLEMENTATION (EC.2.2) - The safety management plan is implemented.

MAINTAIN, TEST AND INSPECT (EC.2.11) - Safety elements of the environment of care are maintained, tested, and inspected.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

4-2 REQUIREMENTS FOR COMPLIANCE

A. MANAGEMENT PLAN

The safety management plan addresses:

- (1) Establishment and management's support of a safety program that is based on monitoring and evaluation of installation safety incidents and experiences;
- (2) The establishment of an installation safety committee composed of administration, clinical services, and support services personnel;
- (3) The establishment of departmental safety committees;
- (4) Designation of a safety officer, appointed by the service unit director and qualified by experience or education, who is responsible for developing, implementing, and monitoring the installation's safety management plan;
- (5) Delegation of authority for the safety officer to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings at the installation;
- (6) Promotion of an ongoing hazard surveillance program, including response to product safety recalls;

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- (7) Requiring the clear directional designation (lighted signage) and accessibility of the emergency room from all main entrances of the installation;
- (8) Establishment of an orientation and education safety training program;
- (9) Requiring documentation of inspections, maintenance and supervision of all grounds, sidewalks, roads, and equipment in special activity areas used by patients;
- (10) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. PROCEDURES

Safety management procedures address:

- (1) The necessary individual departmental safe work practices to eliminate, minimize or avoid safety risks in each department.
- (2) The requirements for maintaining a physical environment free of hazards;
- (3) A mechanism for reporting and investigating all incidents that involve patients, visitors, personnel, or property;
- (4) A plan for the removal of snow and ice, if applicable;
- (5) Procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. ORIENTATION AND EDUCATION

The safety management training program addresses:

- (1) Orientation of all new employees;
- (2) Refresher training for all employees;
- (3) Safe work practices to eliminate, minimize or avoid safety risks in each department;
- (4) Reporting of safety incidents.

D. PERFORMANCE STANDARDS

Safety management performance standards address:

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- (1) Staff knowledge and skill requirements regarding their role in the safety program;
- (2) Building safety inspections;
- (3) Documentation of inspections, preventive maintenance, and testing of safety related equipment;
- (4) Occurrence of incidents at the installation.

E. **EFFECTIVENESS REVIEW**

An effectiveness review addresses the safety management program. A written report of the assessment conducted by the safety officer is forwarded through the safety committee to the Governing Body for approval.

4-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental safety management plans;
- B. Departmental training plans and training records;
- C. Documentation of building safety inspections;
- D. Documentation of inspections, PM, and testing of safety related equipment;
- E. Annual effectiveness report; and
- F. Conducting random staff interviews to determine employee knowledge of the safety program.

CHAPTER 5 - SECURITY

5-1 STANDARDS

MANAGEMENT PLAN (EC.1.4) - A management plan addresses security.

IMPLEMENTATION (EC.2.3) - The security management plan is implemented.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

5-2 REQUIREMENTS FOR COMPLIANCE

A. MANAGEMENT PLAN

The security management plan addresses:

- (1) Establishment and management's support of a security program that is based on monitoring and evaluation of installation security incidents and experiences;
- (2) Security concerns regarding patients, visitors, personnel, and property;
- (3) The establishment of an identification system, as appropriate, for all patients, visitors, and staff;
- (4) Establishment of a training program;
- (5) Specifies personnel, as directed by the service unit director, who are responsible for developing, implementing, and monitoring the installation security program;
- (6) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. EMERGENCY PROCEDURES

Security management procedures address:

- (1) Departmental security practices to eliminate, minimize or avoid security risks and control access, as appropriate, to

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sensitive areas such as medical records, pharmacy, medication rooms, drug storage vaults, and other similar locations;

- (2) Practices in the emergency room that address staff dealing with the risk factors associated with assaultive behavior by patients;
- (3) A mechanism for reporting and investigation of all security incidents that involve patients, visitors, personnel, or property;
- (4) Vehicular access and traffic control to emergency service areas;
- (5) Actions for handling situations involving civil disturbances (riots);
- (6) Actions for handling situations involving VIPs and/or the presence of media (newspapers, television) at the installation;
- (7) Emergency staffing plans for personnel response to control human and vehicle traffic in and around the installation grounds and buildings during security related incidents;
- (8) Procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. **ORIENTATION AND EDUCATION**

The security management training program addresses:

- (1) Orientation of all new employees;
- (2) Refresher training for all employees;
- (3) Access control, as appropriate, to sensitive areas;
- (4) Vehicular access and traffic control for emergency service areas;
- (5) Reporting of security incidents.

D. **PERFORMANCE STANDARDS**

Security management performance standards address:

- (1) Staff knowledge and skill requirements regarding their role

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in the security program;

- (2) Monitoring and inspection activities of sensitive areas at the installation;
- (3) Documentation of inspections, preventive maintenance, and testing of security equipment;
- (4) Occurrence of incidents at the installation.

E. **EFFECTIVENESS REVIEW**

The effectiveness review addresses the effectiveness of the security management program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

5-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental security management plans (as applicable);
- B. Departmental training plans and training records;
- C. Documentation of security incident investigations;
- D. Documentation of inspections, PM, and testing of security related equipment;
- E. Documentation of sensitive area inspections;
- F. Annual effectiveness report; and
- G. Conducting random staff interviews to determine employee knowledge of the security program.

CHAPTER 6 - HAZARDOUS MATERIALS AND WASTES

6-1 STANDARDS

MANAGEMENT PLAN (EC.1.5) - A management plan addresses control of hazardous materials and wastes.

IMPLEMENTATION (EC.2.4) - The hazardous materials and waste management plan is implemented.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

NOTE:

JCAHO recognizes that there are different definitions of hazardous waste. Federal regulations do not currently define infectious waste or medical waste as hazardous waste. However, the intent of this standard is to implement a management process that includes all materials and wastes that require special handling in order to address identified occupational and environmental hazards. Infectious waste and medical waste fall into special handling category since they involve recognized occupational exposure issues that must be dealt with properly.

6-2 REQUIREMENTS FOR COMPLIANCE

A. **MANAGEMENT PLAN**

The hazmat management plan addresses:

- (1) Establishment and management's support of a hazmat program that is based on monitoring and evaluation of installation incidents and experiences;
- (2) Monitoring and documentation of the levels of hazardous gases or other volatile substances and their disposal whenever they are used in the installation;
- (3) Adequate and appropriate space and equipment for the safe handling and storage of hazardous materials and wastes;
- (4) Requiring material safety data sheets (MSDS) to match each substance in the hazardous material inventory in each area in each department.

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NOTE:

The MSDS sheets must be accessible to employees at the locations the materials are used.

- (5) Establishment of a training program;
- (6) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. PROCEDURES

Hazmat management procedures address:

- (1) The establishment of procedures for selecting, handling, storing, using, and disposing of hazardous materials from initial receipt, utilization and final disposal at the installation;
- (2) The establishment of procedures to identify, evaluate, and inventory hazardous materials and wastes used or generated by each applicable department;
- (3) The reporting and investigation of all hazardous materials or waste spills and exposures or other incidents that involve patients, visitors, personnel, or property;
- (4) The management and tracking of chemical wastes, chemotherapeutic wastes, radioactive wastes, and regulated medical or infectious wastes, including sharps;
- (5) Protocol to be followed by procurement personnel for reviewing all procurement of materials prior to purchasing to determine which are hazardous and require handling as such;
- (6) Employee-Right-To-Know rules;
- (7) Radiology departmental procedures that address:
 - a. Use of collimation on all x-rays performed;
 - b. Use of gonadal shielding;
 - c. Check of technique before exposure;
 - d. Fail-safe determination of possible pregnancy before radiological examination;
 - e. Use of appropriate shielding for personnel;

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- f. Use of film monitoring badges for personnel;
- (8) Departmental procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. **ORIENTATION AND EDUCATION**

The hazmat training program addresses:

- (1) Orientation of all new employees;
- (2) Refresher training for all employees;
- (3) Reporting of hazmat incidents;
- (4) Proper precautions in selecting, handling, storing, using, and disposing of hazardous materials and wastes for those personnel who manage and/or come in contact with hazardous materials and wastes;
- (5) Proper emergency procedures during a hazmat spill or exposure for those personnel who manage or come in contact with hazardous materials and wastes;
- (6) Educating and monitoring of personnel who manage or regularly come into contact with hazardous materials and wastes;
- (7) Health hazards associated with mishandling hazardous materials and wastes within their departments for personnel who manage or come in contact with hazardous materials and wastes;
- (8) Employee Right-To-Know requirements;
- (9) Reporting procedures for hazmat incidents, including spills or exposures.

D. **PERFORMANCE STANDARDS**

Hazmat management performance standards address:

- (1) Staff knowledge and skill requirements regarding their role in the program;
- (2) Monitoring and inspection activities;
- (3) Documentation of inspections, preventive maintenance, and testing of equipment used in the hazmat program;

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(4) Incident occurrence at the installation.

E. **EFFECTIVENESS REVIEW**

The effectiveness review need to addresses the effectiveness of the program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

6-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing;

- A. Installation management plans;
- B. Departmental procedures for handling hazmat spills;
- C. Departmental training plans and training records;
- D. Specific radiology department procedures;
- E. Documentation of employee exposure monitoring records;
- F. Documentation of inspections, PM, and testing of hazardous material related equipment;
- G. Annual effectiveness report; and
- H. Conducting random staff interviews to determine employee knowledge of the hazardous material and waste program.

CHAPTER 7 - EMERGENCY PREPAREDNESS

7-1 STANDARDS

MANAGEMENT PLAN (EC.1.6) - A management plan addresses emergency preparedness.

IMPLEMENTATION (EC.2.5) - The emergency preparedness management plan is implemented.

EMERGENCY DRILLS (EC.2.9) - Drills are regularly conducted to test emergency procedures.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

NOTE:

Disasters are defined as natural or man-made events which cause major disruption at the installation such as damage to buildings and grounds due to severe wind storms, tornadoes and hurricanes, earthquake; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones) due to floods, riots, accidents or emergencies within the installation or in the surrounding community that disrupt the installation's ability to provide health care.

7-2 REQUIREMENTS FOR COMPLIANCE

A. MANAGEMENT PLAN

The emergency preparedness management plan addresses:

- (1) Establishment and management's support of an emergency preparedness program that is based on monitoring and evaluation of installation disaster incidents;
- (2) Defines when appropriate, the installation's role with community-wide emergency preparedness efforts;
- (3) Defines, where appropriate, alternate roles and responsibilities of personnel during disasters and emergencies;

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- (4) Provides for the management of space, supplies, and security during disasters and emergencies;
- (5) Provides for an emergency communication system during disasters and emergencies;
- (6) Provides an identified alternative source for essential utilities;
- (7) Establishment of an alternate care site if the installation cannot continue to support adequate patient care and treatment;
- (8) Establishment of a training program;
- (9) Identifies, where appropriate, available facilities for radioactive or chemical isolation and decontamination;
- (10) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. **EMERGENCY PROCEDURES**

Emergency preparedness procedures address:

- (1) Response to a variety of disasters and potential incidents applicable to geographic location of the installation;
- (2) Notification of proper authorities outside the installation in an emergency;
- (3) Assignment of available personnel to reflect current staffing patterns (manpower plans);
- (4) Evacuation of the installation if it is affected by a disaster and it cannot continue to support adequate patient care and treatment;
- (5) Management of patients during disasters or emergencies, including the scheduling, modification, or discontinuation of services, control of patient information, and admission, transfer, and discharge;
- (6) A installation bomb threat plan;
- (7) An installation riot control plan.
- (8) Departmental procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

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C. **ORIENTATION AND EDUCATION**

The emergency preparedness training program addresses:

- (1) Orientation of all new employees;
- (2) Refresher training for all employees;
- (3) Reporting of disaster incidents;
- (4) Implementation of the Information and skills needed to perform the required duties of the emergency preparedness plan by personnel who are required to participate;
- (5) Specific information detailing roles and responsibilities;
- (6) Back-up method of communication during disasters and emergencies;
- (7) Method of obtaining supplies and equipment during disasters or emergencies.

D. **PERFORMANCE STANDARDS**

Emergency preparedness performance standards address:

- (1) Staff knowledge and skill requirements regarding their role in the emergency preparedness program;
- (2) Effectiveness of the training program;
- (3) Evaluation of the management of staff during a real or drill disaster incident.

E. **EMERGENCY DRILLS**

- (1) The installation implements the emergency preparedness plan semi-annually either in response to an emergency or in a planned drill activity;
- (2) Installations that offer emergency services or are designated as disaster receiving stations have at least one implementation per year that includes an influx of volunteer or simulated patients;
- (3) Disaster drills (or actual disasters) must be separated at least four months to be acceptable.

F. **EFFECTIVENESS REVIEW**

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The effectiveness review needs to address the effectiveness of the emergency preparedness program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

7-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental emergency preparedness plans;
- B. Departmental training plans and training records;
- C. Documentation of disaster drills;
- D. Documentation of inspections, PM, and testing of emergency preparedness related equipment;
- E. Annual effectiveness report; and
- F. Conducting random staff interviews to determine employee knowledge of the emergency preparedness program.

CHAPTER 8 - LIFE SAFETY

8-1 STANDARDS

MANAGEMENT PLAN (EC.1.7) - A management plan addresses life safety.

IMPLEMENTATION (EC.2.6) - The life safety management plan is implemented.

DRILLS (EC.2.10) - Fire drills are conducted regularly.

MAINTAIN, TEST, AND INSPECT (EC.2.12) - Life safety elements in the environment of care are maintained, tested, and inspected.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

8-2 REQUIREMENTS FOR COMPLIANCE

A. MANAGEMENT PLAN

The life safety management plan addresses:

- (1) Establishment and management's support of a life safety (fire protection) management program that is based on monitoring and evaluation of installation safety incidents and experiences;
- (2) The protection of patients, personnel, visitors, and property from fire and the products of combustion through minimizing smoke transmission through control of designated fans and/or dampers in air-handling systems, and transmission of a fire alarm to the local fire department;

NOTE:

Manual transmission of the fire alarm has been approved by the JCAHO but requires that all fire alarm signals:

- a. Must be received at a supervised location within the health care installation;
- b. The supervised location must:

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- * Be attended at all times;
 - * Be protected in the same manner as a hazardous area as required in NFPA 101;
 - * Contain the appropriate equipment to receive the fire signals;
 - * Contain a log in which all fire alarm system status changes are recorded;
 - * Immediately transmit to the fire department all received alarms signals;
 - * Contain a master copy of the installation's fire alarm plan.
- (3) Requires documentation for the inspection, testing, and maintenance of all fire protection systems (fire alarm, sprinkler, automatic extinguishing, fire extinguishers) including quarterly testing of all circuits and annual preventive maintenance of all components, as appropriate to the occupancy classification;
- (4) Requires the management of portable fire extinguishers, including guidelines for the identification, placement and use, a quarterly inspection program, and a regular maintenance program;
- (5) Requires the reporting and investigation of life safety and fire protection deficiencies, failures, and user errors that may threaten the patient care environment during a fire;
- (6) Requires the identification and maintenance of drawings that identify all applicable required structural features of fire protection such as;
- a. Smoke walls;
 - b. Horizontal exits;
 - c. Location of fire extinguishers, fire alarm pull stations, automatic extinguishing hoods, exits, and all sprinkler components (i.e., flow valves, Siamese connection, inspector's test);

NOTE:

Fire separation are all walls required by code to be rated

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one-hour or higher. Generally this includes all hazardous areas (boiler room, medical records, warehouse, kitchen, employee locker rooms, paint shops, trash collection rooms, soiled linen rooms, clean linen rooms, repair shops, flammable or combustible storage larger than 50 sq. ft., horizontal exits, etc.;

Smoke separations are all walls that are required by code to resist the passage of smoke.

- (7) Establishment of a training program;
- (8) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. EMERGENCY PROCEDURES

Life safety management procedures address:

- (1) Installation-wide needs in response to fire;
- (2) Area-specific needs and evacuation routes in response to fire;
- (3) Specific roles and responsibilities of all personnel when at the fire's point of origin;
- (4) Specific roles and responsibilities of all personnel when remote from a fire's point of origin;
- (5) Specific roles and responsibilities of personnel in preparing for building evacuation;
- (6) Issues related to fire safety procurement outlining the acquisition of bedding, window draperies, curtains, furnishings, decorations, and other equipment. The procedure must outline the flammability and smoke rating allowed in each of the buildings in the installation;
- (7) Departmental procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. ORIENTATION AND EDUCATION

The life safety management training program addresses:

- (1) Orientation of all new employees;
- (2) Refresher training for all employees;

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- (3) Reporting of life safety incidents;
- (4) Specific roles and responsibilities of all personnel in the fire's point of origin;
- (5) Specific roles and responsibilities of other personnel (for example, volunteers, students, physicians) to the extent that they are required to participate in the fire plan;
- (6) Use and function of fire protection systems, (sprinklers, fire alarm etc.);
- (7) Specific roles and responsibilities in the event of evacuation within the building (from one smoke compartment to another) or to the exterior of the building;
- (8) Location and proper use of equipment for transporting patients to areas of refuge during evacuation;
- (9) Procedures all personnel should follow to contain smoke and fire through building compartmentalization procedures.

D. **PERFORMANCE STANDARDS**

Life safety management performance standards address:

- (1) Staff knowledge and skill requirements regarding their role in the life safety management program;
- (2) Monitoring and inspection activities;
- (3) Effectiveness of the training program;
- (4) Documentation of inspections, preventive maintenance, and testing of life safety related equipment;
- (5) Occurrence of incidents at the installation.

E. **EMERGENCY DRILLS**

Emergency drills are simulated fire occurrences performed at random to rehearse and evaluate the installation's response to the existing life safety plan.

- (1) All areas of each building are included in the fire drill and observed as part of the drill evaluation;
- (2) Staff on all shifts in entire patient care buildings participate in drills that test their knowledge of the use and function of fire alarm systems; the transmission of

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alarms, the containment of smoke and fire, the transfer to areas of refuge, fire extinguishment, assignment of specific duties, and preparation for building evacuation;

- a. Drills must be performed quarterly per shift per building;
- b. Actual patient movement is not required;
- c. Actual false alarms can count up to 50% of drills, if documented;
- d. Drills must be critiqued and documented for:
 - * The actual drill area;
 - * An adjacent smoke compartment;
 - * A smoke compartment immediately above or below the drill area;
 - * Additional smoke compartments totaling at least 20% of the total building number;

(3) Fire drills exercise all primary elements of the fire plan.

NOTE:

Non-patient buildings also require fire drills per OSHA. However, it does not impact on accreditation.

F. **EFFECTIVENESS REVIEW**

The effectiveness review needs to address the effectiveness of the life safety program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

8-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental fire plans;
- B. Departmental training plans and training records;
- C. Documentation of fire drills;
- D. Documentation of inspections, PM, and testing of life safety

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related equipment;

- E. Annual effectiveness report; and
- F. Conducting random staff interviews to determine employee knowledge of the life safety program.

CHAPTER 9 - MEDICAL EQUIPMENT

9-1 STANDARDS

MANAGEMENT PLAN (EC.1.8) - A management plan addresses medical equipment.

IMPLEMENTATION (EC.2.7) - The medical equipment management plan is implemented.

MAINTAIN, TEST AND INSPECT (EC.2.13) - Medical equipment is maintained, tested, and inspected.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

NOTE:

It is no longer necessary to worry about any documentation for testing, inspecting or maintaining personal property equipment other than clinical or utility. It is encouraged though as a result of good engineering practice that it continue to be tested, inspected and maintained.

9-2 REQUIREMENTS FOR COMPLIANCE

A. **MANAGEMENT PLAN**

The medical equipment management plan addresses:

- (1) Establishment and management's support of a medical equipment program that is based on monitoring and evaluation of failure incidents, equipment disruptions, and maintenance history;
- (2) Establishment of a medical equipment maintenance program by inspection, testing, and maintenance of equipment through;
 - a. PM program procedures;
 - b. Equipment cards;
 - c. Documentation of PM (books/logs/forms);
 - d. Testing and inspection guidelines.

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- (3) Establishment of a requirement to maintain a current (within six months), accurate, unique inventory of all medical equipment in the program, regardless of ownership or purpose;
- (4) Requiring equipment assessments to minimize the clinical and physical risks associated with portable and fixed medical equipment;
- (5) Requiring each piece of equipment be tested prior to use and at least annually thereafter, such testing is documented;
- (6) Requiring monitoring and appropriate action on medical equipment hazard notices and recalls;
- (7) Establishes a training program for medical equipment users and maintainers;
- (8) Requiring reporting incidents in accordance with the Safe Medical Devices Act;
- (9) Establishes the requirements of an annual evaluation of the effectiveness of the program.

B. **EMERGENCY PROCEDURES**

Medical equipment management procedures address:

- (1) Actions to be taken by the clinical engineering staff to restore medical equipment when it fails;
- (2) Clinical interventions to be taken by clinical staff, in each department, (if applicable) when medical equipment fails;
- (3) Availability of and access to spare equipment when equipment fails;
- (4) Actions to obtain repair services when equipment fails;
- (5) Criteria for selection and acquisition of medical equipment;
- (6) Criteria to identify, evaluate, and inventory new and existing medical equipment to be included in the equipment management program. Ownership, purchase, rental or lease options are not a consideration;

The criteria (if utilized) must address;

- * Clinical application (diagnosis, treatment, and

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monitoring);

- * Physical risks associated with the equipment during usage;
 - * Equipment maintenance requirements;
 - * Equipment incident history.
- (7) Reporting of required equipment incidents to the Food and Drug Administration (FDA) in accordance with the Safe Medical Devices Act;

NOTE:

A report is generated when information is received that reasonably suggest that a medical devise may have caused or contributed to the death, serious injury, or illness of a patient.

- (8) Identification, reporting, investigation, and documentation of equipment problems, failures and user errors that have an adverse effect on patient safety and/or quality of care.
- a. Relevant summaries of equipment failures and user errors reported to the safety officer, quality assurance or risk management function;
 - b. When problems are identified, the actions taken to resolve them.
- (9) Radiology department procedures that addresses quality control issues for the following:
- a. Collimation;
 - b. Beam alignment;
 - c. Timers;
 - d. Film processing;
 - e. Image intensifiers and display monitors;
- (10) Departmental procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. **ORIENTATION AND EDUCATION**

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The medical equipment management training program addresses:

- (1) Orientation of all new users and maintainers;
- (2) Refresher training for all users and maintainers;
- (3) Medical equipment's capabilities, limitations, and special applications for its users;
- (4) Basic operating and safety procedures that medical equipment users should follow when using the equipment;
- (5) Proper emergency procedures users should follow when equipment fails;
- (6) Information and skills medical equipment maintainers need to perform the assigned maintenance duties;
- (7) Reporting of equipment problems, failures, and user errors.

D. **PERFORMANCE STANDARDS**

Medical equipment management performance standards address:

- (1) User and maintainer knowledge and skill requirements regarding their role in the medical equipment program;
- (2) Routine emergency and incident reporting procedures, including when and to whom such reports are to be communicated;
- (3) Inspections, PM, and testing of medical equipment.

E. **EFFECTIVENESS REVIEW**

The effectiveness review needs to address the effectiveness of the medical equipment program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

9-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental medical equipment management plans;
- B. Departmental training plans and training records;
- C. Failure/user error summary reports;

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- D. Procedures for all patient care departments that address the operation of equipment that supports the care of patients;
- E. Documentation of inspections, PM, and testing of medical equipment;
- F. Annual effectiveness report; and
- G. Conducting random staff interviews to determine employee knowledge of the medical equipment management program.

CHAPTER 10 - UTILITY SYSTEMS

10-1 STANDARDS

MANAGEMENT PLAN (EC.1.9) - A management plan addresses utility systems.

IMPLEMENTATION (EC.2.8) - The utility management plan is implemented.

MAINTAIN, TEST, AND INSPECT (EC.2-14) - Utility systems in the environment of care are maintained, tested, and inspected.

STAFF ORIENTATION AND EDUCATION (EC.2.1) - Staff members have been oriented to and educated about the environment of care, and possess the knowledge and skills to perform their responsibilities under the environment of care management plan.

NOTE:

Utility systems, for the purpose of accreditation, are defined as electrical distribution, emergency power, elevators, heating, ventilating and air conditioning, plumbing, boiler and steam, medical gases (oxygen, nitrous oxide, medical air, medical/surgical vacuum), or communication systems (data exchange systems, paging, telephone and nurse call).

10-2 REQUIREMENTS FOR COMPLIANCE

A. **MANAGEMENT PLAN**

The utilities management plan addresses:

- (1) Establishment and management's support of a utilities management program that is based on monitoring and evaluation of installation failure incidents, equipment disruptions, and maintenance history;
- (2) Establishment of a utilities management program by inspection, testing, and maintenance of critical components in the systems through;
 - a. PM program procedures;
 - b. Equipment cards;

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- c. Documentation of PM (books/logs/forms);
 - d. Testing and inspection guidelines.
- (3) Establishment of a requirement to maintain a current (within six months), accurate, unique inventory of all utilities (deemed critical by the installation safety committee):

JCAHO identifies the following as utilities:

Normal Electrical Power	Plumbing
Emergency Electrical Power	HVAC
Nitrous Oxide	Domestic Water
Medical Vacuum	Oxygen
Steam	Medical Air
Chilled Water	Natural Gas
Data Management	Nurse Call
Paging	Telephone

- (4) Establishing a training program for utilities systems users and maintainers;
- (5) Assessing and minimizing the special risks and ensures the operational reliability associated with utility systems;
- (6) Maintaining current utility system operational plans that are written to help ensure reliability, minimize risks, and reduce failures;
- (7) Requiring monitoring and appropriate action on equipment hazard notices and recalls;
- (8) Identifying through the use of sketches or engineering drawings, the distribution of each utility system, including labeling of controls for partial or complete emergency shutdown of each utility system;
 - a. Shut-off valves/breakers need to be labeled at origin;
 - b. Documentation on at least annual testing of valves/breakers.
- (9) Requiring a listing of equipment served by the life safety, critical and equipment branches of the emergency power;
- (10) Documentation showing calculation for compliance with the 30/50% testing rule.
- (11) Establishes a program for training of utility users and maintainers;

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- (12) Establishing the requirement of an annual evaluation of the effectiveness of the program.

B. **EMERGENCY PROCEDURES**

Utilities management procedures address:

- (1) Actions to be taken by the maintenance department to restore each utility during partial or total cessation;
- (2) Actions to be taken by each administrative department (if applicable) during partial or total cessation of each critical utility;
- (3) Clinical interventions to be taken by each clinical department (if applicable) during partial or total cessation of each utility;
- (4) Availability of and access to spare equipment when utility equipment fails;
- (5) Criteria to identify, evaluate, and inventory new critical utility operating components to be included in the utility management program.

NOTE:

If all the utilities equipment is in the utilities management program no criteria for inclusion is necessary.

The criteria (if utilized) addresses:

- a. Life-support systems;
 - b. Infection-control systems;
 - c. Environmental support systems;
 - d. Equipment-support systems;
 - e. Communication systems.
- (6) Identification of alternate sources for essential utilities in the event of disruption or failure;
- (7) Identification, reporting, investigating, and documentation requirements for equipment problems, failures and user errors that have an adverse effect on patient safety and/or quality of care;

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- a. Relevant summaries of equipment failures and user errors are reported to the safety officer, quality assurance or risk management function;
 - b. When problems are identified, actions are taken to resolve them.
- (8) Operating procedures for shutoff controls; to be followed during a utility malfunction or disruption, including notifying staff in affected areas;
- (9) Repair services when a utility fails;
- (10) Departmental procedures are reviewed as frequently as necessary, but no less frequently than every three years. Procedures are distributed, practiced, and enforced.

C. **ORIENTATION AND EDUCATION**

The utilities management training program addresses:

- (1) Orientation of all new users and maintainers;
- (2) Refresher training for all users and maintainers;
- (3) Utilities capabilities, limitations, and special applications for its users;
- (4) Basic operating and safety procedures that users should follow when using utilities;
- (5) Proper emergency procedures users should follow when a utility fails;
- (6) Reporting of utility system problems, failures, and user errors.
- (7) Information and skills maintainers need to perform their assigned duties;
- (8) Location and use of emergency shutoff controls;

D. **PERFORMANCE STANDARDS**

Utilities management performance standards address:

- (1) User and maintainer knowledge and skill requirements regarding their role in the utilities management program;
- (2) Routine emergency and incident reporting procedures,

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including when and to whom such reports are to be communicated;

- (3) Inspections, preventive maintenance, and testing of utility systems.

E. **EFFECTIVENESS REVIEW**

The effectiveness review needs to address the effectiveness of the utilities management program. A report of the assessment conducted by the safety officer is submitted for review through the safety committee to the Governing Body for approval.

10-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Departmental utilities management plans;
- B. Documentation of compliance with the 30-50% generator testing rule;
- C. Documentation that generator fuel supply for at least 24 hours of continuous operation is available on site at all times;
- D. Departmental procedures for addressing actions taken in the event of partial or total cessation of utilities;
- E. Departmental training plans and training records;
- F. Individual and summary (quarterly) utility failure reports that are provided to the safety committee;
- G. Documentation of inspections, PM, and testing of utilities related equipment;
- H. Annual effectiveness report; and
- I. Random staff interviews to determine employee knowledge of the utility management program.

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EXHIBIT 10-2-A
UTILITIES MANAGEMENT
MANAGEMENT PLAN

THE IHS TECHNICAL HANDBOOK FOR HEALTH FACILITIES, VOLUME VI, FACILITIES ENGINEERING, PART 84, UTILITIES MANAGEMENT MEETS YOUR ACCREDITATION REQUIREMENTS.

NOTE:

FACILITIES MANAGERS MUST SUBMIT THE DOCUMENT TO THE SAFETY COMMITTEE FOR CONCURRENCE AND APPROVAL BY MANAGEMENT AT THE SERVICE UNIT.

For Example:

The management plan must require that:

- (1) The emergency generator be tested (exercised).
- (2) Hot water limits will be specified and monitored.
- (3) Utility emergency shut offs will be tagged and exercised.
- (4) Drawings that identify fire protection requirements are available on site.
- (5) A PM program maintain critical utility systems.
- (6) A program tests and inspects critical utility systems.
- (7) The safety committee review and approve any deviation from the approved plan.
- (8) A program of orientation and education for users and maintainers of critical utilities.
- (9) Departments whose health care mission is hampered during failure of critical utilities maintain written contingency plans that outline the departmental actions during failure of each critical utility.
- (10) Sufficient fuel for 24-hour operation of the emergency generator is available on site.
- (11) Significant utility interruptions be reported to the safety committee for risk assessment.
- (12) The effectiveness of the utilities management program be

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evaluated at least annually.

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EXHIBIT 10-2-B
UTILITIES MANAGEMENT
PROCEDURES

THE IHS TECHNICAL HANDBOOK FOR HEALTH FACILITIES, VOLUME VI, FACILITIES ENGINEERING, PART 83, PROGRAM PROCEDURES, UTILITIES MANAGEMENT, CHAPTER 3, WILL ULTIMATELY MEET YOUR ACCREDITATION REQUIREMENTS WHEN COMPLETED BY THE FACILITIES MANAGER AT EACH SERVICE UNIT.

NOTE:

FACILITIES MANAGERS MUST EDIT AND/OR WRITE PROCEDURES AND SUBMIT THEM TO THE SAFETY COMMITTEE FOR CONCURRENCE AND APPROVAL BY MANAGEMENT AT THE SERVICE UNIT.

Procedures should outline:

- (1) What are the requirements (policy)?
- (2) How are requirements going to be accomplished.
- (3) Who is responsible for what in accomplishing the requirements?
- (4) What are the frequencies for testing, inspecting and maintaining utility system components?
- (5) What are the acceptable parameters for testing, maintaining and inspecting utility system components?
- (6) Why is this procedure necessary? (Reference)
- (7) Who needs to review and receive a copy of the procedure?
(Distribution)

For Example:

The following procedures will be written:

- (1) Procedure outlining the testing, inspection and maintenance of the normal and emergency power generator systems.
- (2) Procedure outlining the testing, inspection and maintenance of the HVAC system.
- (3) Procedure outlining the testing, inspection and maintenance of each fire protection system component.

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- (4) Procedure outlining the testing, inspection and maintenance of the medical gas system.
- (5) Procedure outlining the testing, inspection and maintenance of the elevator.
- (6) Procedure outlining the exercising of emergency shut offs.
- (7) Procedure outlining the inspection of boilers.
- (8) Procedure outlining the testing, inspection and maintenance of the potable water system.
- (9) Procedure outlining the testing, inspection, and maintenance of the plumbing system.

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EXHIBIT 10-2-C
UTILITIES MANAGEMENT
PERFORMANCE STANDARDS

The following performance standards will be utilized to measure the effectiveness of the utilities management program.

- (1) The emergency generator will be tested in such a manner that it will comply with the 30 or 50% rule.
- (2) Preventive maintenance of utilities equipment will be accomplished as scheduled at least 80% of the time.
- (3) Significant utility interruptions will be reported to the safety committee within 30 days 90% of the time.
- (4) Testing and inspections of equipment will be accomplished 100% of the time.

Failure of equipment to pass inspection and testing will require immediate corrective action or the equipment will be put out of service and the contingency failure plan will be put into effect.

- (5) Significant utility interruption incidents will be decreased by 30% as compared to the previous year or no significant utility interruptions will occur during the year.
- (6) Refresher training and orientation education for all users and maintainers of critical utility systems was accomplished during the year.

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EXHIBIT 10-2-E
UTILITIES MANAGEMENT
EFFECTIVENESS REVIEW

NOTE:

THE EFFECTIVENESS REPORT IS PREPARED AND SUBMITTED TO THE SAFETY COMMITTEE BY THE INDIVIDUAL RESPONSIBLE FOR IMPLEMENTATION OF THE PROGRAM ELEMENT AT THE SERVICE UNIT.

For Example:

The following actions will meet accreditation requirements:

- (1) Supervisors of the department where an interruption of a critical utility occurs will prepare the utility incident report and forwards it to the Facilities Manager.
- (2) A quarterly utility interruption incident report is prepared by the Facilities Manager and forwarded to the safety committee through the safety officer.
- (3) An annual effectiveness report is prepared by the Facilities Manager and forwarded to the safety committee through the safety officer.
- (4) The safety committee reviews, comments, disapproves, recommends or concurs with the evaluation and effectiveness of the utility management program.

CHAPTER 11 - DEVELOPMENT OF AN ICES

11-1 STANDARDS

INFORMATION COLLECTION AND EVALUATION SYSTEM (EC.3) - An organization wide Information Collection and Evaluation System (ICES) is developed and used to evaluate conditions in the environment of care.

APPOINTMENT (EC.3.1) - The organization appoints an individual to direct an ongoing, organization wide process to collect information about deficiencies and opportunities for improvement in environment of care management programs.

ANALYSIS OF IDENTIFIED SAFETY ISSUES (EC.3.2) - The organization analyses identified environment of care safety management issues and develops or approves recommendations for resolving them.

IMPLEMENT AND MONITOR (EC.3.3) - The safety officer works with appropriate staff to implement recommendations and monitor their effectiveness.

11-2 REQUIREMENTS FOR COMPLIANCE

A. **ESTABLISHMENT OF A SAFETY COMMITTEE**

- (1) The Service Unit Director establishes an installation safety committee composed of representatives from administration, clinical services, and support services.
- (2) The committee meets on at least a bi-monthly basis to assess time sensitive issues and to develop or approve recommendations for addressing them. The frequency of meetings should be increased if the annual effectiveness review reveals that the program element is not functioning at the minimum acceptable level .

B. **APPOINTMENT OF A SAFETY OFFICER**

The Service Unit Director appoints an individual, qualified by experience or education, to be responsible for developing, implementing, and monitoring the installation safety program. A delegation of authority letter should authorize the Safety Officer to intervene whenever conditions exist that pose an immediate threat to life or health or pose a threat of damage to equipment or buildings.

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The Safety Officer performs the following functions;

- (1) Leadership of the safety committee;
- (2) Hazard surveillance and review of accident and incident reporting on a regular basis;
- (3) Assists the committee in the development of departmental and organization wide safety procedures;
- (4) Assists the committee in assessing infection control functions that impact any of the environment of care program elements programs.

- C. **SAFETY COMMITTEE MONITORING** - Risk assessments by the committee evaluate the impact on patient and public safety of the buildings, grounds, equipment, occupants, and internal physical systems.

The safety committee monitors the program elements by;

- (1) Establishing a mechanism for review and re-issuance of departmental safety procedures at least every three years;
- (2) Establishing indicators to measure program effectiveness;
- (3) Monitoring and evaluating departmental safety activities through the review of departmental minutes forwarded to the committee.
- (4) The committee evaluates the reports of findings, recommendations, and actions resulting from reviews performed by individuals charged with evaluating the various program elements. Their conclusions and recommendations serve as the process for the safety committee to review, evaluate, and recommend improvements to the environment of care by the Governing Body.

- D. **SAFETY COMMITTEE ANALYSIS AND ACTION** - The committee documents its reviews and recommendations through its meeting minutes.

Analysis and action involve:

- (1) Incidents that involve property damage, occupational illness, and patient, personnel, or visitor injury;
- (2) Risk-assessments of program element;
- (3) The issues identified by the safety committee are communicated at least quarterly to the Governing Body.

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- (4) Committee actions and recommendations are routed to appropriate departments for implementation through the committee minutes.

11-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Safety Officer appointment letter;
- B. Safety Officer delegation of authority letter;
- C. Safety committee membership roster;
- D. Installation and departmental minutes of safety committees;
- E. Annual summary report for any or all program elements;
- F. Conducting interviews with safety committee members;
- G. Conducting interviews with installation employees;

CHAPTER 12 - THE SOCIAL ENVIRONMENT

12-1 STANDARDS

ESTABLISH A SOCIAL ENVIRONMENT (EC.4) - The hospital establishes a social environment that supports its basic mission and services.

APPROPRIATE SPACE (EC.4.1) - Appropriate space to support services is provided.

GROOMING AND PERSONAL HYGIENE (EC.4.1.1) - Articles for grooming and personal hygiene that are appropriate to the patient's age, developmental level, and clinical status are readily available.

CLOSET AND DRAWER SPACE (EC.4.1.2) - Closet and drawer space are provided for storing personal property and those items for use by the patients.

PATIENT POSITIVE SELF IMAGE (EC.4.2) - An environment that fosters a positive self-image for the patient and preserves his or her human dignity is provided.

DOOR LOCKS AND STRUCTURAL RESTRAINTS (EC.4.2.1) - Door locks and other restraints used are consistent with the hospital's mission and program goals.

PATIENT CLOTHING (EC.4.2.2) - Hospitalized patients was clothing suitable to their clinical condition.

PATIENT PRIVACY (EC.4.3) - Adequate privacy to reflect sensitivity and respect for the patient is provided.

TELEPHONES (EC.4.3.1) - A telephone is available to all patients for private conversations.

SLEEPING ROOM DOORS (EC.4.3.2) - Sleeping rooms have doors for privacy, unless clinically contraindicated.

PATIENTS PER ROOM (EC.4.3.2.1) - The number of patients per room is appropriate to the hospital's goals and to patients' ages, developmental levels, and clinical needs.

PATIENT ACTIVITIES (EC.4.4) - Activities to support the development and maintenance of the patient's interests, skills, and opportunities for personal growth are provided.

PATIENT FURNISHINGS AND EQUIPMENT (EC.4.4.1) - Furnishings and

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equipment suitable to the population served are available.

PATIENT OUTDOOR ACTIVITIES (EC.4.4.2) - As appropriate to the length of stay, the hospital accommodates the needs of patients to be outdoors, unless contraindicated for therapeutic reasons.

12-2 REQUIREMENTS FOR COMPLIANCE

- A. The installation provides appropriate and adequate interior and exterior space and equipment;
- B. The environment is comfortable, safe, clean, and attractive;
- C. The environment allows good social and recreational interchange;
- D. The environment assures auditory and visual privacy;
- E. Patients have adequate arrangements for leisure-time activities that attend to the patient's individual needs.

12-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by:

- A. Walk-thru of the installation;
- B. Staff and patient interviews; and
- C. Reviewing governing body policies and procedures.

CHAPTER 13 - SMOKING

13-1 STANDARD

SMOKING (EC.5) - A nonsmoking policy is communicated and enforced throughout all buildings.

EXCEPTIONS (EC.5.1) - Any exceptions to the prohibition are authorized for a patient by a licensed independent practitioner's written authorization, based on criteria that are defined by the medical staff.

13-2 REQUIREMENTS FOR COMPLIANCE

These standards are intended to restrict smoking to a minimum in an installation. The restriction of smoking is intended to:

- A. Reduce the risks to the patient associated with smoking, including its possible adverse effects on the patients's treatment;
- B. Reduce the risks to other patients and staff that are associated with passive smoking;
- C. Reduce the risk of fire;
- D. Patient smoking, if authorized by a physician, must occur in a location that is environmentally separate from all patient care areas;
- E. There is to be no smoking by visitors and staff within the installation's buildings.

13-3 SURVEYOR'S VERIFICATION OF COMPLIANCE

The JCAHO surveyor will verify compliance by reviewing:

- A. Policies addressing smoking;
- B. Staff patient interviews;
- C. Building tour

NOTE:

There is no mention in the standards prohibiting smoking outside the buildings. Therefore there is a need to develop a written policy specifying where smoking is allowed and under what circumstances.

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Adequate signage is also needed to restrict smoking in some areas of the installation (i.e., fuel oil tanks, outside medical gas storage etc.).